Pembroke Care (Reading) Limited

Pembroke Lodge

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Good**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on 13 August 2015, and was unannounced.

Pembroke Lodge is a care home which offers accommodation for people who require personal care. At the time of our inspection there were 17 residents. The registered manager told us this was their choice as they felt they could best support 17 people than the 20 they are registered for. Some of the people living at the service may require specialist care associated with dementia. We have recommended specialist training in the subject of dementia.

A registered manager was in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff knew how to keep people safe by reporting concerns promptly. Systems and processes were in place to recruit

Summary of findings

staff who were suitable to work in the service and to protect people against the risk of abuse. There were sufficient numbers of suitably trained and experienced staff to ensure people's needs were met.

We observed good caring practice by the staff. People and relatives of people using the service said they were very happy with the support and care provided.

People told us communication with the service was good and they felt listened to. All people spoken with said they thought they were treated with respect, preserving their dignity at all times.

People were supported with their medicines by suitably trained, qualified and experienced staff. Medicines were generally managed safely and securely. However, where medicines were required to be administered on an as required basis, guidelines were not available.

People received care and support from staff who had the appropriate skills and knowledge to care for them. All staff received induction, training and support from experienced members of staff. Whilst staff stated they felt supported by the management and said they were listened to if they raised concerns it was found that supervisions, appraisals and team meetings were held infrequently. This potentially affected the level of support staff had to carry out their duties.

People who could not make specific decisions for themselves had their legal rights protected. People's support plans showed that when decisions had been made about their care, where they lacked capacity, these had been made in the person's best interests. However care plans and risk assessments were found not to be updated in conjunction with changing needs of people. This could therefore mean that care was not always responsive or effective in response to care needs. We have made a recommendation about developing individuality and choice.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. Applications had been made as required, and were recorded on the providers computer system.

It was found that quality assurance audits and governance of documents were completed by the service. This therefore allowed continual assessment and changes to be made where the service felt necessary. However audits of documents related to care and wellbeing were not completed.

We found these issues to be breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not maintained accurate records in order to meet the requirements of the fundamental standards. You can see what action we told the provider to take at the end of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

People were safeguarded from abuse and staff understood how to report any concerns they had.

Plans in an emergency were in place. These were robust, providing succinct details.

The provider had a strong recruitment procedure in place. People were kept safe with the current staffing ratios. Medicines were managed safely.

Good

Is the service effective?
The service was not always effective.

People received timely support from appropriate health care professionals.

Staff training was updated on a regular basis.

Staff did not receive regular supervision and appraisals. Team meetings were held infrequently. Residents meetings were held infrequently.

The premises did not respond to people's continuing health needs, specifically in the internal aesthetics of the building for people with dementia.

Requires improvement

Is the service caring?
The service was caring.

Staff worked in a caring, patient and respectful way, involving people in decisions where possible. They respected people's dignity and privacy.

Staff knew people's individual needs and preferences well. They gave explanations of what they were doing when providing support.

Good

Is the service responsive?
The service was not responsive.

There was a system to manage complaints and people felt confident to make a complaint if necessary.

A programme of activities was provided for the service as a whole. Activities were not individualised and did not focus on the needs of the individual.

Written care plans were not reviewed regularly and were not updated with appropriate risk assessments in relation to people's changing health needs.

Requires improvement

Is the service well-led?
The service was not well-led.

Requires improvement

Summary of findings

Staff, people and professionals found the management approachable and open. The registered manager did not have a clear process for ensuring a full overview of the service.

No effective processes were in place to monitor the accuracy of the care provided.

No audits had been completed to identify where improvement were needed in relation to care documentation.

Care plans and risk assessments were not written by the service and therefore were not updated as required.

Pembroke Lodge

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. We also want to look at the overall quality of the provision, and be able to provide a rating for the service under the Care Act 2014.

This inspection was carried out by one inspector on 13 August 2015 and was unannounced. The first day of the inspection was carried out at the service.

Prior to the inspection the local authority care commissioners were contacted to obtain feedback from them in relation to the service. We referred to previous inspection reports, local authority reports and notifications. Notifications are sent to the Care Quality Commission by the provider to advise us of any significant events related to the service.

During the inspection we spoke with five members of staff, including one domestic, three support staff, the deputy manager and the Registered Manager. We spoke with two people who live at and use the service, as well as family members of three people who use the service. We used the Short Observational Framework for Inspection (SOFI) during the inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. This was used over teatime. We further completed a general observation during handover, to see how information was shared between staff.

Care plans from health professionals, health records, medication records and additional documentation relevant to support mechanisms were seen for five people. In addition a sample of records relating to the management of the service, for example staff records, complaints, quality assurance assessments and audits were viewed. We looked at staff recruitment and files for five of the regular staff team.

Good

Is the service safe?

Our findings

People were being kept safe. There were comprehensive recruitment procedures included staff being vetted to ensure they were appropriate to work with people. This included obtaining references for prospective staff to check on their behaviour in previous employment and a Disclosure and Barring Service (DBS) check. A DBS check allows employers to ensure an applicant has no criminal convictions which may prevent them from working with vulnerable people. We found that DBS applications were made for all staff, and that correct records were kept for the "Adult First" check (part of the DBS check to establish if an applicant is barred from working with vulnerable adults).

People who use the service and their relatives felt that staff kept people safe at Pembroke Lodge. One person reported they felt, "Completely safe" whilst another person's family member reported, "yes kept safe… given all the attention that she needs." Staff had a good understanding of both the safeguarding and whistleblowing procedures. They were able to explain the actions they would take if they witnessed or had concerns about abuse. Training records showed staff had undertaken training in safeguarding people against abuse and this was refreshed on a regular basis. Individual risk assessments had been carried out, for example, those associated with moving and handling and poor nutrition. Changes to risks were communicated promptly to staff at handovers however these were not always documented in updated risk assessments and care plans, or reviewed as required.

Staffing levels were observed to be safe and sufficient, to meet people's care needs. A relative reported, "There's always someone around to help". Staff also felt that a sufficient number of staff were available to keep people safe and to respond appropriately to care needs. Rotas for the last six weeks were reviewed and found to illustrate that the minimum staffing requirements had been met. Where necessary the management had covered the rota personally so as to ensure that all people were safely cared for. No agency staff were used at the service which ensured continuum of care was provided at all times.

Medicines were supplied and delivered by a community based pharmacy. They were stored safely in locked trollies and placed in the communal rooms for people. However, the medicine that was kept in the fridge was found not to be stored in a locked box, but placed in the kitchen fridge amongst foods. This was highlighted as a risk of cross contamination and against NICE 2014 guidelines. Medicines were ordered and managed by one of the team leaders. Any unused medicines were returned to the community pharmacy. Regular audits were carried out by the management so as to ensure the safe ordering, management and storage of medicines in the locked trolley. Some people were prescribed medicines to be taken when necessary. We found that guidelines were not in place to allow staff to establish when these needed to be taken. Staff stated they understood when this medicine should be administered, but recognised the need for this to be recorded and appropriately risk assessed.

Incidents and accidents were monitored regularly with any noticeable trends being further explored, assessed and managed. For example, one person on respite care was found to have managed to open the front door and leave the premises The service offered the person an alternative bedroom and reviewed the locking mechanism on the front door. This incident occurred just prior to the respite care coming to an end, therefore the home did not apply for a DoLS. The service spoke with the family and suggested a comprehensive assessment of the person's needs be carried out by the relevant medical practitioner.

The service had evacuation procedures in place. Staff were able to correctly describe what action needed to be taken in the event of a fire and fire drills were carried out to ensure staff were both familiar with and understood the procedure. Fire equipment was regularly tested to ensure it was safe to use in case of fire. The provider had a contingency plan which outlined clear instructions for staff to follow should there be an emergency; this included alternative accommodation with contact details.

Regular maintenance checks were carried out on the building and equipment. A list of work was produced for the maintenance staff and if additional work requiring specialist skills was needed this was requested through head office. Work would then be undertaken by the provider's maintenance team or outsourced to approved contractors.

People were protected against environmental risks to their safety and welfare. Staff monitored general environmental risks, such as hot water temperatures, fire exits and slip and trip hazards as part of their routine health and safety checks. Other household equipment and furniture was seen to be in good condition and well maintained. Service

Good

Is the service safe?

contracts were in place to regularly service equipment in use, such as hoists, lift and fire equipment. One person required bedrails; these were appropriately padded to prevent the possibility of entrapment.

Requires improvement

Is the service effective?

Our findings

People were cared for by a team of staff who underwent a detailed induction process. This included completion of the provider's mandatory training and additional training that would be supportive to them in their role. Before commencing work they shadowed experienced staff until they felt confident to work independently. The training matrix showed that all training for staff within the home was either up to date or booked. Training was sourced by an external training company.

People felt staff had the skills they needed when supporting them. One relative told us person told us: "they are kind." We observed staff working with people and providing assistance. At all times they were skilful and professional. On going staff training was monitored and we saw all training perceived by the provider as mandatory was up to date. The mandatory training included: fire safety, moving and handling, first aid, food hygiene, safeguarding adults and health and safety. Staff were also due to undertake training in dementia.

Staff told us that they were positively supported by management however, they did stress that supervisions were infrequent as were appraisals. Team meetings were not held consistently, this caused issues due to an inability to discuss any issues collectively as opposed to individually. Information was provided by the registered manager via email; however there were concerns about the security of potentially sensitive information being sent to personal email addresses.

People's rights to make their own decisions, where possible, were protected. Staff received training in the Mental Capacity Act 2005 (MCA). The MCA provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. The MCA also requires that any decisions made on behalf of a person who lacks capacity, are made in the person's best interests. Management had an understanding of the MCA and staff were aware of their responsibilities to ensure people's rights to make their own decisions were promoted.

The requirements of the Deprivation of Liberty Safeguards (DoLS) were being met. The DoLS provide legal protection for vulnerable people who are, or may become, deprived of their liberty. Applications for DoLS had been made to the relevant authorities, and were being followed up after the initial referral process.

People received effective health care and support. People could see their GP and other health professionals such as psychiatrists and nurses as and when required. Contact sheets showed that specialist health professionals were consulted as necessary. The advice provided by the professionals was adhered to; however this was not always appropriately recorded in care plans. This could lead to the possibility of ineffective care being received by people.

A SOFI completed during teatime, illustrated that people were offered a selection of sandwiches and hot drinks. People were observed eating and discussing the meal. One person said "I'm not particularly enjoying it, but that's all that is available". Meal planners were seen, and showed that choice was not offered for hot or cold meals. We spoke with the people regarding this, and whether they had spoken to staff in relation to food choice. We were told this had not been raised.This was discussed with the chef. We were advised that more choice would be made available and that people would be consulted in relation to the foods that they would like to eat.

People were observed during the day of the inspection, seated along the perimeters of the communal room potentially leading to a reduction in socialisation. Tables were placed in front of people. Whilst this did not necessarily mean they were restricted, it could lead to people not being able to move around freely. One person was observed during the day using the quiet room. This room had recently been created with a built in fish tank in the wall. The room offered people the opportunity to relax listening to music, or take in the view of the garden. French doors created direct access to the garden for people. Several people who use the service had either been diagnosed with or showed signs of living with dementia. There was no evidence that guidance on best practice had been sought for people living with dementia. Bedrooms although personalised, did not have room numbers, or any external identification to mark them, no signage was available for people living with dementia to orientate them to the right areas. The home generally was not making relevant alteration to accommodate the changing needs of people. This was discussed with the deputy manager who informed us that a new member of staff had recently raised

Requires improvement

Is the service effective?

this point. Information related to The King's Fund and The University of Sterling were given to the service as avenues to consider referring to, when adapting the home for people living with dementia.

We recommend that the service seek advice and guidance from a reputable source with regard to appropriate training for staff in relation to dementia care and dementia friendly environments.

Good

Is the service caring?

Our findings

People were treated with care and kindness. During the SOFI we observed staff speaking to and approaching people with care. Staff were observed gently placing their hand on people's shoulder, and coming down to their level when talking to them. This was witnessed throughout the day during the inspection. One family member said "[Name] is treated like an individual. The atmosphere is fun and caring", whilst a person using the service reported "they are very caring".

Care plans were devised through discussion with family members and people using the service. Where necessary external professional advice was sought. It was evident that staff knew people well and responded to their needs appropriately. However, documentation was not always kept up to date to reflect this.

People's personal history was used to establish things they liked and disliked. This was then transferred into daily conversation by staff when speaking with people. We found that this information was not being used to devise activities that people could benefit from. This was discussed with staff, who advised they would discuss this with the activity coordinator and ask for this to be incorporated into individual personalised activity plans.

Staff had an understanding of equality and diversity. People's right to confidentiality was protected. All records were kept securely. Visits from health professionals were carried out in private in people's own rooms. We observed staff protected people's rights to privacy and dignity as they supported them during the day and any personal care was carried out behind closed doors. Staff were observed asking before entering people's room.

Residents and next of kin meetings had been reintroduced by the service. These had not been offered frequently historically, however we were reassured by management that they intended to run these regularly. This would allow people the opportunity to discuss any issues that they may have and offer a chance to meet in a collective social setting.

Requires improvement

Is the service responsive?

Our findings

People had their needs assessed prior to them moving into the service. The staff were responsive to the needs of people after their move, and to the effect that their presence may have on other people. However, care plans were not appropriately updated to illustrate accurate care needs and how to manage these. Whilst this was not an immediate concern due to staff knowing each person for whom they provide care, this could potentially present a risk of inconsistency in care should new staff or agency be required. The service was introducing a new electronic recording system. This was for daily logs, rather than a full care and support plan. Staff were unable to provide evidence of audit for either the care related paper or electronic systems appropriately.

People were offered activities within a group setting on a daily basis. These were offered either in the communal lounge or the garden. We were shown videos of internal and external entertainers who had performed at the service. We found that people were not offered individual activities. One member of staff said “Need more activities, usually sit here and do nothing. No individual activity plans." An activity plan was located in the entrance hall, this detailed activities for the home from the previous month. An up to date activities schedule was not available for us to see. We were unable to find evidence of people's specific interests being catered for, as individual activity plans had not been created. We were told that an activity coordinator was being recruited to focus on this area moving forward.

Staff were observed to recognise when people were becoming distressed or needed assistance. For example, in one instance when a person was becoming upset due to not being able to locate their purse, staff appropriately responded calming the person and lowering their anxiety.

People were supported to maintain relationships with their family and friends. We saw visitors were welcomed warmly to the home and were offered drinks during their visit. However, we were told by the registered manager and found on the notice board that visiting hours were determined by the service. This was further discussed with the registered manager, to determine the reason behind this. We were advised this was to prevent people becoming agitated or confused during personal care time. Family members stated they understood the reason why this was put into place.

People were aware of how to make a complaint and told us they would speak to one of the management. Complaints were dealt with quickly and resolutions were recorded along with actions taken. Family members stated that they would speak with one of the managers, however they never had a reason to complain.

We found that 15 of the 17 people who use the service were seated within the communal lounge for the entirety of the day. We asked staff if people wanted to be in the lounge. Staff were unable to determine if this was a choice for the people concerned, or whether this was something that had become a system within the service. People said they were used to coming into the communal room in the mornings and returning to their bedrooms in the evening. It was unclear if this was something they were happy doing, or a routine. “This is what we do”, said one person. Staff reported that they would look into ensuring this was the choice of the person and not something they were doing because they were told to.

We recommend that the service seek advice and guidance from a reputable source with regard to appropriate training for staff in relation to personalised care.

Requires improvement

Is the service well-led?

Our findings

We found that whilst staff knew how to provide care and treatment to people, accurate records were not always maintained to show this. This was therefore neither reflective of the good care provided nor did it cover changes in people's needs. Any potential new staff coming into the service could by default provide care by following an out of date care plan or risk assessment. This would mean that the service would not be meeting the current needs of the person. The registered manager did not complete internal audits of systems and paperwork. This meant there was no continual evaluation of the care service leading to improvements. The absence of reviewed risk assessments for people was a further concern. These were found to be in breach of Regulation17HSCA 2008 (Regulated Activities) Regulation 2014.

At the time of the inspection the registered manager had been working at the service for over 20 years. Within that time a significant rapport and relationship of trust had been built with the families of people who use the service. One family member reported, "My mother used to be here, I wouldn't put my [relation] anywhere else." The registered manager had an open door policy. People using the service, staff, relatives or other professionals had the opportunity to raise any concerns or complaints with the registered manager at any time.

There was an honest and open culture in the home. Staff showed an awareness of the values and aims of the service. For example, they spoke about giving the best care and respecting people. One staff member said, "Big family culture. Everyone enjoys working here". Staff told us the management regularly checked on the care provided, whilst engaging with people. They told us they felt able to voice their opinions or seek advice and guidance from them at any time. They told us the registered manager was open and approachable and created a positive culture but was not afraid to speak to staff if they did not perform to the standards expected.

During the inspection we found that the registered manager had delegated many of the duties to the deputies. Whilst this is an effective management style, in this case it had led to gaps in the manager's oversight of the service. We had concerns that the registered manager was not fully aware of issues within the service. For example, the registered manager did not know that care documentation was not adequately up to date. When seeking to locate information and documentation during the course of the inspection, the registered manager was not aware of where all the relevant documentation was held.

The provider carried out annual quality surveys with people living at the service. The last survey was carried out in May 2014. Once the survey forms were returned and analysed a report would be written of the results and management would draw up an action plan to deal with any issues raised.

We found that the communication within the home was good. Handover and shift planners were used. These were verbally worked through and completed on the tablet electronically so reference could be made to them during the course of the shift. A communication book was in place which allowed supplementary information to be passed onto staff; this was located in the communal room. We spoke with staff and suggested that confidential information may be contained in this, therefore this may be breaching confidentiality. Staff removed the communication book immediately. A diary was used to detail appointments, schedule meetings and indicate training bookings.

There was strong evidence of working in partnership with external professionals. Documentation used within the service was written by the professionals involved in the care of the people. The home had evidence of maintenance checks being carried out by the provider.

The registered manager told us that care shifts consisted of four staff working an early shift and four on late shifts with two waking nights on the premises each night. The registered manager advised that any staff shortfall was covered by the management team. When looking through the rotas we found that the staff from the residential service were being used to cover Domiciliary Care Agency DCA hours offered by the same company and registered at the same location. A DCA offers personal care support to people who live in their own homes or hold private tenancies. This was raised with the registered manager as a concern during the visit. We were subsequently advised that additional staffing had been added to the rota so to ensure that staffing levels remained consistent within the home, and were not affected by the DCA.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person did not have systems or processes established and operated effectively to ensure compliance with the requirements in this Part. Regulation 17(1). The registered person did not assess, monitor and improve the quality of the services provided in the carrying out of the regulated activity. Regulation 17(2)(a). The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided. Regulation 17 (2)(c). The registered person did not seek or act on feedback from relevant persons and other persons on the services provided, for the purposes of continually evaluating and improving such services. Regulation 17 (2)(e). The registered person did not have a system that enabled the registered person to evaluate or improve their practice in respect of the processing of information. Regulation 17 (2)(f).